North Carolina
Department of Health and Human Services
Division of Medical Assistance
Director's Office
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TO: DMA Staff
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FROM: Gary Fuquay

SUBEJCT: POLICY INSTRUCTIONS: Early Periodic Screening, Diagnosis and Treatment Services (EPSDT)

Background

Federal Medicaid law at 42 U.S.C.§ 1396d(r) of the Social Security Act, requires state Medicaid programs to provide periodic screening, diagnosis, and treatment (EPSDT) for recipients under age 21. Within the scope of EPSDT benefits under the federal Medicaid law, states are to cover any service that is medically necessary "to correct or ameliorate a defect, physical and mental illness, or a condition identified by screening", whether or not the service is covered under the State Plan.

The services required to be provided under EPSDT are limited to services that are within the scope of the services listed in the federal law at 42 U.S.C. § 1396d(a) of the Social Security Act (see attachment). This memorandum addresses the procedures used to assure proper EPSDT services are available.

Operational Steps

- Whenever state staff or contractors review a request for prior approval or continuing authorization (UR) for an individual under age 21, the reviewer will apply EPSDT standards to the review. This means that the decision to approve or deny will be based on the individual's medical need for the service to 'correct or ameliorate' a diagnosed condition if the service is within the federal list of EPSDT benefits. Normal service limitations to scope, amount or frequency will not apply if the service is necessary. For example, personal care services must be covered for a recipient under age 21 if needed in that case to "correct or ameliorate" an illness or condition, because personal care services are within the services on the attached list.

  Moreover, EPSDT requires that the particular service which is needed "to correct or ameliorate" the individual's illness be provided. It is not sufficient to offer a standard service by a more local or lower cost provider if the standard or lower cost service will not correct or ameliorate the condition. If a more specialized methodology is needed in that individual case, it must be provided, assuming that the more specialized methodology is listed within the scope of services set forth in 42 U.S.C. § 1396d(a). A specific type of medical equipment, therapy, or other service must be covered if that particular service is necessary to correct or ameliorate the condition in that individual case.

  - ✓ If other DMA or DMH instructions include an established numerical limit of hours per month, a maximum number of visits, an established list of covered services or equipment, or another restriction on covered services, the reviewer will consider necessity for the service without consideration of those limitations.

  - ✓ If the treatment/service is not determined to be medically necessary, is experimental in nature, or is not within the scope of benefits which may be covered under the federal Medicaid law, it cannot be covered under EPSDT.

  - ✓ If there is no established review process for a requested service or the service is not covered under NC's state plan, the request will be forwarded to the DMA Assistant Director for Clinical Policy and Programs. DMA will determine whether the service is permitted under federal Medicaid law and, if so, is it medically "necessary to correct or ameliorate" for the individual recipient.

- Providers or family members may write directly to the Medicaid Director requesting review for a specified service.

- ✓ DMA (in coordination with DMH when the issue involves mental health, developmental disability or substance abuse) retains the authority to determine how an identified type of equipment, therapy or service need will be met, subject to compliance with federal law, including consideration of the opinion of the treating clinician, recipient freedom of choice of provider, and sufficient access to alternative services.

- ✓ DMA (in coordination with DMH when the issue involves mental health, developmental disability or substance abuse) will arrange for, directly or through appropriate referral, treatment which the recipient under age 21 needs under this EPSDT policy. DMA will enroll providers, set reimbursement rates, set provider qualifications, and assure the means for claims processing when the service is not already established in the state plan.

- ✓ A decision on the service will be acted on with reasonable promptness. The provider and recipient/family must be notified in writing of a prior approval denial, or any reduction or termination of services using the prescribed state form. When a decision is made to deny services or reduce/terminate services for a recipient under age 21, the decision must specify the reasons why the EPSDT standard is not met. The reason should be cited in the decision. Such a denial can be appealed in the same manner as any Medicaid service denial, reduction or termination.

Relationship to CAP waiver services

- Waiver services are available only to participants in the Community Alternatives waiver programs and are not part of the EPSDT benefit. A recipient under age 21 receiving waiver services who is financially eligible for Medicaid whether or not enrolled in the waiver may elect to receive necessary EPSDT services in addition to waiver services. *(Note: Should the cost of a waiver participant become excessive, the cost neutrality requirements for Home and Community Based Waivers may cause the individual to lose a waiver slot. However, this individual may continue to receive necessary services under the EPSDT provisions without regard to an upper cost limit.)*

- A recipient under age 21 on a waiting list for CAP services who is an authorized Medicaid recipient without regard to approval under a waiver, is eligible for necessary EPSDT services without any waiting list being imposed.

EPSDT Information

This policy instruction shall remain posted at both DMA and DMH websites. DMA and DMH will regularly inform their staff, related DHHS Divisions, contractors, agents, Medicaid providers, families, and other agencies working with children on Medicaid (e.g. schools, Headstart, WIC, Smart Start, etc.) about this EPSDT policy and its procedures for EPSDT services (including DME equipment/supplies). A summary of this policy and procedure, and a reference to the website address where it is posted, will be included in the Medicaid Consumer Guide for Families, in annual inserts with Medicaid cards, and in Medicaid provider bulletin articles at least annually. All affected staff and contractors will receive training on EPSDT policy and procedures.

DHHS Divsions Directors will transmit this policy to their respective staff members and local agencies.

(Attachment)

ATTACHMENT TO EPSDT POLICY STATEMENT

Listing of EPSDT Services Found in the Social Security Act at 1905(a)

- Inpatient hospital services (other than services in an institution for mental disease)
- Outpatient hospital services
- Rural health clinic services (including home visits for homebound individuals)
- Federally-qualified health center services
- Other laboratory and X-ray services (in an office or similar facility)
- EPSDT *(Note: EPSDT* offers periodic screening services for recipients under age *21 and Medicaid covered services* necessary to correct or ameliorate a *diagnosed physical* or mental condition)
- Family planning services and supplies
- Physician services (in office, patient's home, hospital, nursing facility, or elsewhere)
- Medical and surgical services furnished by a dentist
- Home health care services, including nursing services, home health aides, medical supplies and equipment, physical therapy, occupation therapy, speech pathology, audiology services
- Private duty nursing services (in the recipient's private residence)
- Clinic services (including services outside of clinic for eligible homeless individuals)
- Dental services
- Physical therapy and related services (includes occupational therapy and services for individuals with speech, hearing, and language disorders)
- Prescribed drugs
- Dentures
- Prosthetic devices
- Eyeglasses
- Other diagnostic, screening, preventive, and rehabilitative services, including medical or remedial services recommended for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level (in facility, home, or other setting)
- Services in an intermediate care facility for the mentally retarded
- Inpatient psychiatric hospital services for individuals under age 21
- Services furnished by a midwife, which the nurse-midwife is legally authorized to perform under state law, without regard to whether or not the services are performed in the area of management of the care of mothers and babies throughout the maternity cycle
- Hospice care
- Case-management services
- TB-related services
- Respiratory care services
- Services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner, which the practitioner is legally authorized to perform under state law
- Personal care services (in a home or other location) furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease
- Primary care case management services
- Any other medical care, and any other type of remedial care recognized under state law, specified by the secretary (includes transportation)